saber-toothed tiger. *Requiescat in pace mortuorum.* The new civilization must have no religious wars. Civically, it must be neither for nor against religion. Each man, whether "infidel" or believer, must be free to settle with God for himself.

Third: No closed seas and no hostile fleets must ever separate the races from the field of their food supply. The future food supply for Europe is to come from Africa. The unused and arid lands of that continent must be equitably divided for reclamation and cultivation; and no Gibraltar-Suez line must ever intervene. The Mediterranean, in peace or in war, must cease to exist as a barrier between kitchen and storehouse. And no transverse line from Sicily to Tunis must divide East from West. The Mediterranean must be made a free highway for all races.

I have written, in the work to which reference has been made, of other problems which a rebuilt world civilization must face. These that I have now written are the problems of a rebuilt Europe. And Europe must face them or die.

3901 Marmion Way.
August 20, 1937.

JOSEPH P. WIDNEY,
Los Angeles.

HOSPITAL RADIOLOGISTS AND PATHOLOGISTS

The California Medical Association has now come out in favor of having doctors who practice radiology and pathology rent space (and equipment) of hospitals instead of having the hospital hire the doctors.[1] Two very enlightened men—one a radiologist, the other a hospital administrator—laid the groundwork of principle for this plan, and other enlightened men are adhering to these principles.

We are aiming to better the care of sick people. It is necessary that doctors do well enough financially so that able minds may be attracted to medicine as a career. It is necessary that hospitals make a financial success or decent hospital care will cease to be available. What magic is there in a particular type of financial arrangement between a hospital and a doctor (radiologist, pathologist) that will better the lot of both of them?

The matter would seem to rest at bottom on the professional side. The opportunity to cultivate his career for his own professional and financial advancement ought to attract as able men to hospital quarters as to downtown offices. There would be a displacement of a couple of types of laboratory specialists that one still sees often in hospitals, namely, the one not able or not experienced enough to stand on his own feet, and the one whom economic necessity forces to give first attention to his downtown office, leaving the hospital in the second place.

An able man building his own career in hospital quarters will pick up the responsibilities that go with this freedom. He will be always in the one place—his hospital office, which will encourage the staff doctors to ask him personally about findings and proposed examinations. His work will be tied to his name, his services will be of a doctor to other doctors and their patients. Criticisms of his work will come direct to him and not to the hospital management. Doctors will tell the radiologist to send for a patient and examine her chest, instead of telling the floor nurse to "get a chest x-ray." This gives him a chance to find out what is being searched for and an opportunity to mobilize the resources of his specialty. If he can make his examinations more helpful, he will be more often called upon. If he has unique abilities, patients will be sent even from downtown to make use of them.

The hospital staff, seeing more intimately the work of pathologist and radiologist, might voice their conviction as to whether Dr. A or Dr. B is good enough to be allowed to rent space in their hospital.

The radiologist renting space will be courageous in investing in new equipment, even more than where it devolves on the hospital, for he will have not only the need to keep his department technically efficient, but also to advance himself professionally.

It is not that the pathologist and the radiologist will do perfectly when "on their own." They will make all the usual mistakes of doctors. Availing themselves of permission to collect their own bills, they will likely pile up uncollectible accounts in a way no hospital business manager would tolerate. Yet even this shortcoming, being a mark of freedom, ought to be cherished. It is still permitted, we believe, to hold for the private practice of medicine.

As pathologists and radiologists do take on this recommended rental arrangement with their hospitals, and so gain opportunity to build themselves *in a hospital* a real medical career, they will have to conduct themselves like doctors, not technicians. They will have to get their shoulders under the responsibilities of caring for sick people. They will have to look as closely at their patients as at their shadows and effluvia. They have the opportunity of teaching the well-to-do to pay well and like it—and the duty of caring for the dead-beat for nothing, and liking that (or pretending to with as good grace as may be).

Theirs will be a difficult career. They will have to satisfy their patients, who do not know what is good medicine and what is bad; and also to convince their referring physicians, who do know or ought to.

Anyhow, here is opportunity—the possibility to develop in hospitals radiologists and pathologists who are not just doers of medical chores, but who can cultivate careers in which they can really take pride.

And when they have made a success they will be able to afford to pay their hospital a rental not inferior to what the hospital nets from its rooms. Moreover, the presence in the hospital of these successful specialists will prove attractive to the staff, whose patients make the hospital's prosperity.

The report refers also to university hospitals. The obligations and opportunities of teaching and

1 CALIFORNIA AND WESTERN MEDICINE, 46:419, June, 1937.

of leadership only accentuate the considerations already commented on. A pathologist or radiologist who accepts a straight salary, turning the fees from his practice into the school funds, may feel well repaid by the opportunities for research and some relief from the necessity to cultivate a private practice in order to make a living. But what a medical school does must have an influence on what the medical profession will take as acceptable. Schools ought, one would say, to lead as well as to point the way to what is best in the practice of medicine in general.

Stanford University Hospital.

ROBERT R. NEWELL,
San Francisco.

NEONATAL MORTALITY IN SAN FRANCISCO*

For the past decade the infant mortality rate in San Francisco has steadily declined. In 1934, the rate dropped to an all-time low of thirty-three per one thousand live births from thirty-nine in 1933, at which point it had been stationary for two years. A slight rise to thirty-five was seen in 1935, and a marked increase to forty-two occurred in 1936, the circumstance surrounding which rise having previously been described.[1]

NEONATAL PERIOD USED IN THIS STUDY

In San Francisco, as in other cities, the majority of the infant deaths occur in the neonatal period, which for the purposes of this study was considered under fifteen days. Other factors which vary from year to year influence the total rate, but over a period of ten years the neonatal death rate has been practically stationary. It was with this fact in mind that the present study was undertaken in order to determine, if possible, what factors were present in maintaining the rate level. Could this rate be reduced or had we reached that theoretical point called the irreducible minimum?

SAN FRANCISCO HOSPITAL FIGURES

It may be of direct interest to point out that the Department of Public Health, through the San Francisco Hospital and its out-patient obstetrical department, delivered in 1933, altogether, 18.2 per cent of the total births that occurred in San Francisco. In 1934, the same agencies delivered 15.5 per cent; in 1935, 14.2 per cent; and in 1936, 11.2 per cent. This reduction is quite remarkable, and is perhaps the most sensitive index to the return of a better economic era.

It could be further pointed out that the ratio of births delivered by these services of the Department of Public Health and the low mortality rate of thirty-three in 1934 may be of some significance. Likewise, the rising infant mortality rate which has occurred in the city and county of San Francisco since 1933 and the decrease in the number of births delivered by the services of the Department of Public Health may be equally significant. It is desired to state, however, that no criticism is intended of the private physician, nor any credit assumed for the excellent record of the departmental services, because it is realized that the pregnant woman, in selecting a physician, quite often materially delays the decision and, in our experience, the private physician does not see the case as early as the out-patient clinic of the Department of Public Health.

For the past six years the out-patient obstetrical service of the Department of Public Health has performed the Wassermann test on all pregnant women coming under its supervision. It may be of additional interest to show that the percentage of positive Wassermann tests has averaged approximately 4 per cent.

NEONATAL DEATHS STUDIED

A total of 231 neonatal deaths occurring between January 1, 1936 and April 30, 1937, were studied. These represent a typical section out of any period in the last decade with reference to the relative

* From the office of the Director of Public Health, City and County of San Francisco.

1 "Infant Mortality in San Francisco," California and Western Medicine, Vol. 47, No. 2 (Aug.), 1937.

TABLE 1.—*Premature Birth (159*)*

Cause of Death	Autopsy			No Autopsy		
	Male	Female	Total	Male	Female	Total
Prematurity	18	7	25	31	21	52
Atelectasis	13	11	24	8	11	19
Preëclamptic toxemia	--	--	--	0	3	3
Asphyxia	--	--	--	3	0	3
Enteritis-diarrhea	1	1	2	0	2	2
Acute yellow atrophy of liver	--	--	--	0	1	1
Convulsions	--	--	--	0	1	1
Respiratory infections	1	1	2	1	1	2
Hemorrhagic disease new-born	1	0	1	--	--	--
Totals	34	20	54	43	40	83

* International List No., 1930.